



PADONA /LTCN

Pennsylvania Association of
Directors of Nursing Administration

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PADONA ENews



Dear PADONA Members,

It is almost impossible for me to believe that December has arrived! 2018 is quickly coming to a close.

November continued to be a busy month for PADONA! We hosted 26 participants in our inaugural, "Survival Skills for the LTC Nurse" class. A huge thank you to Becky Flack for her instruction and Terri Gabany and Grove Manor for the gracious hospitality! We also offered two outstanding webinars provided by Premier Therapy and PCA Pharmacy.

Our 2019 convention registration is filling at a swift pace, so don't miss the opportunity to register! You have the opportunity to gear your educational programming toward your professional development needs / goals. The convention is an opportunity for learning, networking, fun, and even a little relaxation...oh, and let's not forget...shopping!

We continue to explore a training partnership with APIC to provide education and training for our members on the Phase III infection control and infection preventionist training. Our goal is to apply for grant money to offer the training in a cost effective and time efficient manner.

We have put forth a Call for Nominations for our Area I board representation. I hope that you will consider volunteering your talents and expertise on our Board and/or through the various Board Committees. This is your opportunity to help shape and guide the organization to best meet the needs of its membership.

PADONA is now on LinkedIn! Please follow us on both Facebook and LinkedIn!



I want to personally thank the members of our Board of Directors who selflessly volunteer their time and effort to support me and the organization! We also have numerous individuals who volunteer their time through committee work to provide counsel and expertise on the various aspects of our operations. I am personally grateful for each and every one of you and I look forward to continuing the work of PADONA in 2019.

Wishing you and yours a safe and healthy Holiday Season and a 2019 filled with many blessings!

Merry Christmas,

Candace McMullen
PADONA Executive Director/Board Chair



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Leadership Development Series

How Well do you REALLY Listen?

Listening is different from hearing. Hearing is a physiological function...whereas listening is a choice. It is a skill that requires development. It is not inherent. Too often, we choose not to listen. Why? Active listening takes effort. It requires us to pay attention and acknowledge the speaker and confirm that we received the intended message. In truth, most of us are not good listeners!

There are many, many behaviors that keep us from listening well. Below are a few of the most common. How many of these are YOU guilty of?

1. I anticipate what people will say next as they are speaking.
2. I'm crafting my own response while the speaker is speaking.
3. I interrupt while the speaker is talking.
4. If I find the topic or the speaker boring, I tune out.
5. If I don't like what the speaker is saying or if it's too hard to understand, I tune out.
6. I am busy, so I keep working while the speaker is talking to me.
7. I listen only to the words, and not the feelings behind the words.

A successful leader is an active listener. In fact, as a leader, we should listen more than we speak. Think about what you learn by listening! You will hear new ideas...opinions...approaches! In listening to others, you demonstrate that you value the speaker and you care about what s/he is communicating. Through the art of active listening, you encourage contributions from others. Respected studies show that leaders who listen have more positive interactions with their teams, and in turn, those teams are more likely to be more favorably influenced by these leaders. Your effectiveness as a leader is directly tied to your ability to actively listen! Hopefully, you are also influencing your team by modeling behavior that you expect from others.

How do we hone our listening talents? First step...make the commitment! Second Step...start practicing good listening technique:

1. Concentrate on what is being said. Pretend you will have a quiz on the speaker's content and need to repeat it to someone.
2. Paraphrase for clarity. For example, "What I think you've said is..."
3. Put aside distracting thoughts. If you need to jot something down so you won't forget it, do that so that you can give full attention to the speaker.
4. Wait until the speaker has finished talking before you speak.
5. Defer judgment. The speaker might be saying something that you disagree with, but s/he still deserves the respect of being listened to.
6. Ask questions if you do not understand what is being said.
7. If you are face-to-face with the speaker, look the speaker in the eye. If you are on the phone, use phrases that acknowledge you're listening (for example, "I see," or "uh-huh").

Start today by selecting just one of your bad listening habits and practice improvement strategies daily until you are successful!



Want to be a better leader? The first step is to Listen Better!

-Anne Weisbord

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I want to highlight a new service that I'm providing: coaching via phone. I work with leaders, managers, supervisors who need help with the people side of their jobs. I address topics like those I've been writing about here as well as issues around conflict resolution, managing your managers, being influential, working with boards, etc. Please contact me if I can be of assistance in helping you become the best leader you can be. aweisbord@outlook.com

Anne Weisbord, president of Career Services Unlimited, has been a communications/leadership consultant for over 20 years. She has worked with health care professionals in a wide range of settings, helping them become more compelling, confident, and articulate speakers and leaders. She has been a keynote speaker and presenter at senior care facilities, nursing organizations, and in staff development in hospitals. She has had personal experience working closely with long-term care staff. www.awlearningconsultants.com.

Clinical Pearls

If It's Red...It's infected...Right?

Nick Zaksek Pharm D. December 2018

Issues in the management of skin and soft tissue infections are common in long-term care facilities and these patients sometimes have multiple admissions to the hospital. These admissions often generate antibiotic prescriptions. I just wanted to share differing views and make a connection between nursing homes and hospitals.

NURSING HOME SIDE:

The McGeer criteria was developed by a panel of experts in 1991. McGeer criteria were created primarily for surveillance and comparative statistics. The Loeb criteria were developed in 2001 by a conference that included many of the same experts who created the McGeer criteria. Loeb intended to address a clinical dilemma: physicians sometimes felt the need to initiate antibiotic therapy in frail residents before all the criteria of the McGeer criteria were met. Both Criteria for nursing homes are used to determine when to start antibiotics for skin & soft tissue infections.

McGeer Criteria	Loeb Criteria
PUS or 4 of the following:	PUS or 2 of the following:
New or worsening warmth	New or worsening warmth
Redness	Redness
Swelling	Swelling
Tenderness	Tenderness
	Fever
Serous drainage or A constitutional finding: * fever, * leukocytosis of 14,000 ≥ * delirium	*serous drainage NOT included



Unless there is purulent drainage, attempting to culture skin infections is neither required nor recommended.

What are the skin conditions that are frequently inappropriately treated with antibiotics in nursing home residents?

- Stasis dermatitis, moisture-related dermatitis, contact dermatitis, and pressure-related skin injuries.
- Contact dermatitis is often an additional confounding factor especially when topical interventions have been attempted.
- Viral rashes such as herpes zoster also can be mistaken for bacterial cellulitis.

Of these, the most common condition is stasis dermatitis, sometimes also referred to as stasis eczema. Every case of “bilateral cellulitis of the lower extremities” is not cellulitis. A history of recurrent episodes of bilateral redness and swelling of the lower extremities is a classic description of stasis dermatitis. Cellulitis is unilateral and rarely bilateral. These patients have underlying venous insufficiency with increased venous pressure leading to extravasation of inflammatory materials into subcutaneous tissue. Some have elements of CHF or severe renal insufficiency as well, but for many the problem is just venous.

Many of these patients have chronic brawny discoloration of the legs from hemosiderin deposits under the skin. *Hemosiderin* results when vein valves fail and regurgitated blood forces RBC and iron storage components out of the capillaries into subcutaneous tissues.

Many of the patients besides having hemosiderin, develop stasis ulcers, and chronic itching related to the materials deposited in the subcutaneous tissue. Scratching, cracking, oozing or ulceration appear as portals for bacteria invasion and might encourage practitioners to go down the wrong road and prescribe antibiotics.

HOSPITAL SIDE:

Patients are admitted to the hospital for IV therapy and antibiotics...They magically improve! The improvement is not because of antibiotics but more from the patient being in bed with leg elevations. If the diagnosis is not corrected, measures to treat the underlying problem will not be started and a cycle will recur with multiple admissions to the hospital and several courses of antibiotics administered over and over. Nursing home staff are very conscientious about getting everyone out of bed, to a chair, ensuring meals are taken in the dining room or sitting up, and providing ambulation to the toilet. All the elements of “great nursing care” will produce leg dangling with gravitational edema of the legs and result in the dermatitis recurring.

Venous insufficiency with stasis is a mechanical problem and the treatment is largely mechanical as well. Medications such as diuretics may help some patients with co-existing CHF. Leg elevation allows gravity to assist the failing venous valves, and along with compression with ACE bandages or compression stockings is the primary treatment. If a patient feels itching or tenderness, topical corticosteroids used sparingly may provide relief along with Unna boots if ulceration is present. Compression carries a cautionary note if patient has arterial insufficiency.

Moisture-related dermatitis is less frequently mistaken for cellulitis because it's typical of patients/residents with urinary and fecal incontinence with distribution around the groin and buttocks. Occasionally, moisture tracking to the back and thigh can appear as cellulitis when the moisture macerates the skin. Don't be fooled...no antibiotics needed. Redness around gastrostomy or other ostomy sites also is mistaken for a skin infection. This is not cellulitis but contact dermatitis from gastric acid or chemicals that may be present in the urine or stool...no antibiotics needed.

The clinician must temper the desire to prevent sepsis with a careful consideration of another possible diagnosis and a restraint from using antibiotics for reddened areas of the body that are not necessarily infected.



Vendor Spotlight

PADONA's December Vendor Spotlight is Career Services Unlimited (CSU).

Anne Weisbord, President and Founder of CSU provides our ENews leadership series. Since 1990, Career Services Unlimited has been helping organizations and individuals achieve their professional development goals through creative, high-energy training and coaching. We focus on improving communication, presentation skills, work life quality, leadership and productivity. Whether you are a profit or non-profit, you can benefit from our highly acclaimed training programs and coaching sessions focused on the needs of your people, your business, and your culture. Anne now offers remote coaching.

The comment below from one of Anne's clients says it all:



Anne Weisbord has been a communications/ leadership consultant for over 20 years. She has worked with health care professionals in a wide range of settings, helping them become more compelling, confident, and articulate speakers and leaders. She has been a keynote speaker and presenter at senior care facilities, nursing organizations, and in staff development in hospitals. She has had personal experience working closely with long-term care staff.

Anne works with her clients to understand the culture of the organization and the levels and needs of participants in order to develop custom-designed programs. Through coaching, workshops, webinars or teleconferences, employees have the opportunity to bring about positive changes which can provide them with more energy and focus in their jobs. Clients gain a greater confidence in their abilities as well as the practical tools necessary to put their learning into practice.

Anne Weisbord

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Turning potential into reality

Avoiding G Level Citations with Incidents and Accidents

[A Closer Look at the Regulatory Requirements F689](#)

§483.25(d) Accidents.

The facility must ensure that –

- 1) The resident environment remains as free of accident hazards as is possible; and*
- 2) Each resident receives adequate supervision and assistance devices to prevent accidents.*

The intent of this requirement is to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes:

1. Identifying hazard(s) and risk(s);
2. Evaluating and analyzing hazard(s) and risk(s);
3. Implementing interventions to reduce hazard(s) and risk(s); and
4. Monitoring for effectiveness and modifying interventions when necessary.



Interpretive Guidance

Processes in a facility's interdisciplinary systematic approach may include:

Identification of hazards, including inadequate supervision, and a resident's risks of potentially avoidable accidents in the resident environment

Identification of hazards and risks is the process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident.

All staff (e.g., professional, administrative, maintenance, etc.) are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident.

Various sources provide information about hazards and risks in the resident environment. These sources may include, but are not limited to,

- Quality Assessment and Assurance (QAA) activities,
- Environmental rounds,
- MDS/CAAs data,
- Medical history and physical exam,
- Facility assessment as required in F838, and
- Individual observation.

Evaluation and Analysis of hazards and risks

Evaluation and analysis is the process of examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents.

Analysis may include, for example, considering the severity of hazards, the immediacy of risk, and trends such as time of day, location, etc.

Both the facility-centered and resident-directed approaches include evaluating hazards and accident risk data which includes prior accidents/incidents, analysis to identify the root causes of each hazard and accident risk, and identifying or developing interventions based on the severity of the hazards and immediacy of risk. Evaluations also look at trends such as time of day, location, etc.

Implementation of individualized, resident-centered interventions, including adequate supervision and assistive devices, to reduce individual risks related to hazards in the environment

Implementation refers to using specific interventions to try to reduce a resident's risks from hazards in the environment.

The process includes:

- Communicating the interventions to all relevant staff,
- Assigning responsibility,
- Providing training,
- Documenting interventions (e.g., plans of action developed by the Quality Assurance Committee or care plans for the individual resident), and
- Ensuring that the interventions are put into action.

Facility-based interventions may include, but are not limited to,

- Educating staff,
- Repairing the device/equipment, and
- Developing or revising policies and procedures.



Resident-directed approaches may include:

- Implementing specific interventions as part of the plan of care,
- Supervising staff and residents, etc.

Facility records document the implementation of these interventions.

Monitoring for effectiveness and Modification of interventions when necessary.

Monitoring is the process of evaluating the effectiveness of care plan interventions.

Modification is the process of adjusting interventions as needed to make them more effective in addressing hazards and risks.

Monitoring and modification processes include:

- Ensuring that interventions are implemented correctly and consistently;
- Evaluating the effectiveness of interventions;
- Modifying or replacing interventions as needed and
- Evaluating the effectiveness of new interventions.

Clinical Areas Covered Under F689

- Supervision to prevent accidents
- Safe smoking
- Resident-to-resident altercations
- Physical plant, devices, and equipment based on resident vulnerabilities, including but not limited to: scissors, kitchen utensils, knitting needles, handrails, assistive devices, items in disrepair, chairs or beds that are not the proper height or width for the resident to transfer to and from safely, lighting that is either inadequate or so intense as to create glare, improper actions or omissions by staff such as fire doors that have been propped open, disabled locks or latches, nonfunctioning alarms, buckled or badly torn carpets, cords on floors, irregular walking surfaces, improper storage of toxic chemicals, exposure to unsafe heating unit surfaces, and unsafe water temperatures.
- Falls
- Unsafe wandering/elopement
- Chemicals and toxins
- Drugs and therapeutic agents
- Plants and other “natural” materials found in the resident environment or in the outdoor environment
- Water temperatures
- Electrical safety
- Assistive devices for mobility: Devices for resident care, such as wheelchairs, pumps, ventilators, mechanical lifts, and assistive devices, may be hazardous when they are defective, disabled, or used in a manner that is not per manufacturer’s recommendations or current professional standards of practice.
- Devices associated with entrapment risks such as bed rails, regular mattresses that are ill-fitting, or specialty air-filled mattresses
- Assistive devices for transfer: Mechanical lifts and other assistive devices may be hazardous when they are defective, disabled, or used in a manner that is not per manufacturer’s recommendations or current professional standards of practice.

A Look at Recent Citations

In calendar year 2018, F689 was cited a total of 219 times with 28.1% of providers cited for a deficient practice. Of the 219 times it was cited, 51 of those citations were cited at a G level or higher.

Immediate Jeopardy Findings



therapy room was left unlocked and unattended with an unlocked hydrocollator holding hot steaming water, measuring 161.4 degrees Fahrenheit (F).

A facility failed to provide supervision and monitoring of food temperatures related to microwave use on seven of eight nursing units and left medication unattended for one resident. This failure to monitor food temperatures of food reheated in microwaves put residents at high risk for a burn injury and resulted in an Immediate Jeopardy situation.

Another facility failed to adequately supervise and maintain each resident's environment to ensure that the residents remained free of accident hazards created by increased temperatures of hot liquids served to residents. One resident sustained a hot beverage spill, resulting in actual harm to that resident. This failure placed residents at a high risk for injury, and resulted in an Immediate Jeopardy situation.

A facility failed to provide adequate supervision and implement interventions to meet a resident's needs, or to properly respond to an acute change in the resident's medical condition from a fall for one resident reviewed, which resulted in actual harm of blunt force trauma followed by death to that resident. This failure placed all residents, who might sustain an accident, at a potential for high risk of harm from injury, and resulted in an Immediate Jeopardy situation.

A facility failed to adequately supervise and maintain a safe environment for a resident with suicidal ideations, who accessed the roof through an unsecured second-floor window resulting in the potential for serious harm. This failure placed the resident at a high risk for injury and resulted in an Immediate Jeopardy situation.

Actual Harm Findings

Facility failed to prevent a resident accident that resulted in harm for one resident reviewed, who sustained a fractured left femur. The facility also failed to implement planned interventions to prevent falls for two of two residents reviewed.

- A physician's order requested an occupational therapy assessment related to the resident leaning over to the side of her wheelchair. The occupational therapy evaluation documented that the resident had poor posture in a standard wheelchair, with right cervical and trunk lean. Further documentation revealed that the resident had impaired wheelchair mobility and was a high fall risk. It was further documented, the therapist trialed various leg rests/footboards with education provided to the caregiver on the rationale and use of the footboard and leg rest. The therapist educated that when being pushed in a wheelchair that leg was tending to move off leg rest and a footboard was added for safety.
- Staff was escorting the resident down the hall in a wheelchair and the resident's right foot got caught on the floor causing the resident to fall forward onto the floor. Documentation did not indicate the footboards were in place at the time of the fall.
- Resident sustained a fractured femur secondary to the fall.
- There was also no policy in place to include specific protocols for wheelchair use and safety in residents listed as a high fall risk.

Facility failed to ensure that necessary assistance devices were in place during mobility to prevent an accident resulting in a fractured lower leg for one resident.

- A resident was seen by OT for the management of appropriate positioning while out of bed. OT directed that this resident was to be positioned out of bed in a low seated Broda chair with bilateral elevating leg rests with a foot buddy. The resident's chair was to be in the tilted position at all times except for eating.
- A facility investigation report revealed that two nurse aides transferred the resident from the Broda chair to her bed via a mechanical lift. During the transfer, the nurse aides reported to a licensed nurse that the resident's left leg was observed to be bruised and swollen.
- An employee witness statement indicated that earlier that day when the nurse aides were transferring the resident from the bed to the Broda chair, they removed the lift pad from underneath the resident. One nurse aide then moved the Broda chair away from the cabinet to put on the leg rests. The resident's left leg went under the chair and twisted a little bit. The employee noted that the resident showed no signs of pain. "I rubbed it and it was fine. She didn't flinch, there was nothing abnormal about the leg. I put the leg rests and her foot positioning device on the wheelchair".



- The second employee witness statement revealed that she assisted the other Nurse Aide when she got the resident out of bed via the mechanical lift. "We took the sling out from underneath her and the Nurse Aide stated that 'she had it from there.'" The second Nurse Aide left the room.
- Doppler studies completed initially were noted to be negative. The physician then ordered an X-ray of the resident's left leg from the knee to the foot. The X-ray report of the left knee revealed that the resident had a displaced fracture of the left tibia and a subacute Fibular head fracture.

Facility failed to provide adequate staff supervision to prevent an elopement by one resident. Facility staff failed to adequately supervise this resident to prevent the elopement and failed to provide age-appropriate diversional activities.

- A review of the facility policy Wandering and Elopement revealed that the facility developed a layered system of protection to prevent elopement. Once a resident is identified as being at risk, an individualized elopement/wandering care plan will be developed and implemented and interventions initiated. The system begins with a comprehensive resident assessment for elopement risk. The second layer is an ongoing facility assessment for elopement risk. The third layer is covered by our individualized interdisciplinary plan of care addressing each resident's elopement risk assessment. The fourth layer contains eyes on visual location check of each resident a minimum of every two hours. The fifth layer is to educate staff on the importance of elopement prevention through the monitoring of the facility exits and resident identification as well as elopement resolution.
- The resident was admitted to the facility with a physician order for the use of a Wander Guard and to check the function of the device every shift
- The resident was independent with transfers and ambulation, but required supervision, oversight, encouragement and cueing with locomotion off the unit.
- An Elopement Risk assessment revealed that the resident was at risk of elopement and the interventions put in place to address this resident's risk was the use of a Wander Guard.
- Nursing progress note revealed staff observations to include multiple phone calls to his spouse, pacing while on the phone and repeated requests by the resident, while on the phone, to be taken out for a visit.
- The facility completed another Elopement Risk Assessment of the resident which indicated that the resident was now not at risk for elopement. A new physician order noted to discontinue resident's Wander Guard. The resident was capable, aware and in agreement.
- Review of the resident's clinical record and care plan revealed no documented evidence that the facility had planned and provided increased supervision of the resident following removal of the resident's Wander Guard. The resident signed himself out of the nursing unit on the sign-out sheet at 4:00 PM, noting the documented destination as the facility's Multipurpose Room.
- A review of a facility incident report revealed that resident eloped from the facility on the same date and was returned to the facility by staff approximately 30 minutes later.
- An employee witness statement revealed that while on break, she drove to Dunkin Donuts, located down the street from the facility. This employee saw this resident crossing the street. The employee returned the resident to the facility. At that time the resident stated that he wanted to go see his wife and wanted to see if he could do it. The resident was found to have no injuries. A BIMS indicated that the resident was cognitively intact with a score of 15.
- Review of the facility's video surveillance noted that the resident exited the multipurpose room courtyard door wearing a coat. The resident was viewed on video surveillance to jump the fence by the ambulance exit. The resident then walked away from the facility and out of video surveillance range.
- Interview with resident following return to the facility noted that he "was bored at the facility".



The facility failed to provide a resident who was identified at risk for falls with adequate staff supervision and timely staff intervention to prevent this fall with serious injury.

- Severely cognitively impaired resident whose plan of care noted he required the assistance of two persons for bathing, dressing and all aspects of transfers.
- A nurse aide was dressing the resident while the resident was sitting at the edge of the bed. There was no other staff assisting the employee. The employee left the resident and walked to the side of the bed to adjust the height of the bed. At that time, the resident fell forward hitting the left side of his face and body on the floor. The resident was sent to the emergency room for evaluation of a 5 cm laceration on the right side of his head with bleeding and bruising.

The facility failed to ensure that sufficient staff assistance with activities of daily living was provided.

- A severely cognitively impaired resident required the assistance of two staff members for transfers and ambulation.
- The facility incident report noted resident was seated in a wheelchair in the hallway. An employee assisted him to a standing position. The resident became unsteady and the employee lowered the resident to the floor.
- The facility determined that the employee failed to follow this resident's plan of care for transfer assistance.

A facility failed to ensure that a resident's environment was free of accident hazards, which resulted in actual harm of a resident ingesting a toxic substance.

- This involved a resident with moderate cognitive impairment. The resident plan of care included the resident to be observed by staff every 15 minutes.
- A licensed nurse heard the resident making a grunting noise and having a persistent cough. On arrival to the room, the nurse noted the resident sitting on the side of her bed. The nurse noted acute respiratory distress with labored/rapid breathing 24-28. The resident had a flushed face and clear secretions coming from her nose and mouth. The nurse indicated that it appeared the resident ingested detergent; however, the nurse was unable to account for how much. When the nurse asked the resident what happened, the resident replied, "Water", and pointed to her night table. The nurse noted there was a 16 oz cup with a lid and straw on the night table and next to it was an open container of liquid detergent with approximately 60 ml of detergent poured into the measuring lid. The resident was given a glass of water and the Poison Control Center was called. The facility followed the first aid instructions.
- The resident was placed on oxygen for SPO2 of 84%, blood pressure was 183/110 mm/Hg and heart rate was 112 bpm. The resident was sent to the ER for evaluation and subsequently admitted.
- Hospital records revealed a discharge summary written by the resident's physician that indicated the resident had ingested more than a capful of laundry detergent with bleach alternative in an attempt to commit suicide. The resident was discharged to inpatient hospice.
- Interview with the Nursing Home Administrator revealed that this resident's family did the resident's laundry and the laundry detergent was stored in the resident's room. The facility failed to ensure a resident's environment was free of hazards, which resulted in actual harm.

Facility failed to implement interventions to prevent accidents for two residents resulting in harm for one resident.

Resident One

- This involves a resident with the inability to ambulate independently. Care plan noted staff was to transfer the resident with a rolling walker and one assist. The care plan for alteration in skin integrity indicated that staff would apply dermasavers to both legs when out of bed and during transfers.



- An incident report revealed that staff was transferring the resident from her wheelchair to her bed when she obtained a 5 cm by 2 cm laceration on her right lower leg. She was sent to the emergency room and required 20 sutures.
- Witness statement noted resident was unable to pivot for the transfer and caught her leg on the wheelchair resulting in a skin tear. Nurse Aide did not use a walker when transferring the resident from the wheelchair to the bed nor was the dermasaver on her right leg.

Resident Two

- Review of another resident's fall care plan revealed an intervention for a chair alarm.
- The facility's investigation into the resident's fall revealed that the resident transferred from her wheelchair to a recliner, resulting in a fall with no injury. Further review of the incident report revealed that there was no alarm on the resident's wheelchair at the time of the fall.

Facility failed to implement interventions to prevent accidents. The facility failed to implement interventions to prevent accidents for one resident resulting in harm.

- Staff was to transfer the resident to and from the bed and wheelchair with the assist of two people. The care plan for alteration in skin integrity indicated that staff should provide frequent reminders for the resident to keep her hands inside the sling during transfers with the lift.
- Review of the incident report revealed that a nurse aide was transferring this resident independently, with a sit to stand lift, when her right hand got stuck in between the bathroom grab bar and the lift creating a skin tear and a laceration on her right hand. The resident was sent to the emergency room and required 6 sutures.
- Review of the facility's incident investigation conclusion noted that the nurse aide transferred the resident using a mechanical lift without assistance from a second nursing staff; expectations that have not been met - did not follow mechanical lift policy.

Facility failed to provide physician ordered assistive devices to prevent an accident with injury resulting in harm. The facility failed to provide needed supportive assistive devices for the resident's wheelchair to prevent an accident that caused a severe injury.

- Admission history and physical indicated a resident with a history of stroke with residual right-sided weakness. A physician's progress note indicated the presence of chronic numbness in her right leg from the previous stroke. The resident was cognitively intact.
- An occupational therapy plan of care noted the resident was unable to maintain a safe sitting balance and need for bilateral leg rests on the wheelchair to facilitate increased comfort and support of her bilateral lower extremities.
- Nursing documentation noted right ankle swelling and pain on range of motion. The resident indicated that a nurse aide was pushing her in her wheelchair yesterday and her feet were caught under the wheelchair. The resident did not have her footrests on when she was being transported. A witness statement indicated that another staff member witnessed the nurse aide pushing the resident down the hallway and the nurse aide verbalizing to the resident, "Keep your feet up and where are your leg rests?"
- Radiology report noted soft tissue swelling in her right ankle and a recent bimalleolar fracture.

Facility failed to implement interventions to prevent accidents for one resident resulting in a fall with harm and hospitalization.

- The resident was cognitively impaired and required limited assistance of one person for walking. Additionally, the resident was not steady but was able to stabilize himself without staff assistance.



- Based on fall reports completed by the facility, the resident had a fall with no injuries reported; and a second fall with a skin tear to the face.
- A third fall report revealed this resident lost his balance and fell back into the double door entrance and hit his head. The resident was continuously seated in a wheelchair but did not want to stay seated. A post-fall assessment noted right eye pinpoint and an abrasion on the rear back of his head 0.5 cm X 0.5 cm). The resident was sent to the hospital.
- Review of a facility event report revealed the Registered Nurse (RN) Supervisor and Unit Charge Nurse witnessed the resident fall backward from a standing position, striking his head on the entry door to unit. The resident was immediately assessed and a small (.5 X .5cm) abrasion to the back of his head identified. His vital signs were within normal limits. The resident was admitted to the hospital for a subdural hematoma.
- Review of the resident's care plans revealed no care plan for falls or interventions despite his history of falls and limited functional status for ADLs.
- During an interview with the Nursing Home Administrator and Director of Nursing, they alleged the resident was care planned for falls; however, they could not provide any verification during the investigation. The facility failed to implement interventions that accurately reflected the services to be furnished for this resident resulting in falls.

Medication Administration

- Review of the facility policy, Medication Administration - General Guidelines revealed that during the administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. The cart must be clearly visible to the personnel administering medications.
- Observation on the nursing unit revealed a medication cart in the hall by the dining room. The medication nurse was around the corner from the cart, which was in the front of the nurses' station. The medication nurse was not in the line of sight of the medication cart and could not see the cart. At the time of the observation, the medication cart was unlocked.
- Upon the return of the medication nurse to the medication cart she was asked to identify herself. She falsely gave the name of LPN, when interviewed she stated she was around the corner giving medications to a resident. When asked if she could see the medication cart she responded no. During a later interview, the DON revealed that the medication nurse had misidentified herself and that she was, in fact, a Registered Nurse, an agency nurse, and that she was being removed from the building.
- Also during a tour of the nursing station, it was observed that the door to the room by the end of the nurses' station was open and in the unlocked cabinets were syringes and medications. Interview with a licensed nurse revealed the door is always open "because we do not have a key to the copier located in that room."

Facility failed to implement planned interventions to prevent an accident with serious injury and failed to assess the individual safety needs and implement necessary measures to maintain the safety of residents who smoke.

- The resident required limited assistance of one staff for transfers, ambulation, dressing, and toileting and was moderately cognitively impaired.
- The resident's transfer status was contact guard assist with a rollator walker.
- A review of the current Evaluation of Unsupported Sitting for Toileting revealed that the resident's awareness of safety needs was poor and that it was determined that the resident could not be left alone on the toilet for short periods of time.
- The Incident Report for Falls revealed that the resident was found on the floor in the bathroom of the resident's room complaining of left knee pain. The resident had sustained a hematoma to her left forehead and abrasions to her bilateral knees. The resident stated that she slipped. The floor was found to be wet underneath the resident's buttocks; her pull up was dry and the origin of the wetness was unknown.
- A Witness Statement completed by a Nurse Aide revealed that she walked the resident with the walker from the bed to the bathroom door in the resident's room. The resident told the nurse aide to let her go, so she did. The nurse aide left the bathroom door opened while the resident walked with her walker to the toilet. She looked



away for a second. By the time she ran to the resident the resident was already on the floor. The resident was dry and had black non-skid slippers on the whole time of transfer. The resident was subsequently admitted to the hospital with a fracture.

- An interview with the Director of Therapy indicated that contact guard means that while ambulating the resident, the staff was to have hands-on contact with the resident at all times. During an interview with the nurse aide, she relayed that the resident was to be assisted with ambulation and that she had maintained contact with the resident until the resident said to let her go.

Review of the information provided by the facility revealed three residents as smokers. However, there was no documented evidence that the facility assessed each of these residents for their individual safety needs while smoking.

- An interview with one resident confirmed that she is a smoker. The resident stated that the facility provides smoking times for the residents to go out of the facility to smoke supervised by the facility staff. The resident also stated that her daughter visits her daily and also takes her out of the facility to smoke. The resident stated that the facility holds her cigarettes and lighter, but they do not provide a smoking apron. An interview with the resident's daughter revealed that the facility does not provide the resident with a smoking apron and she was not aware if the facility had conducted a smoking assessment of the resident's safety needs while smoking. The resident's daughter stated that her mother's left side mobility is limited, due to a stroke. The resident's daughter also stated that there have been times when she took the resident outside for a cigarette and had noticed cigarette ashes had fallen onto the resident.
- A second resident stated that she is accompanied by nursing three times a day outside to the front area of the nursing home to smoke. She stated that she lights and holds her own cigarettes and does not wear any protective clothing while smoking. She further stated that nursing staff keeps her smoking materials and gives them to her prior to going to the smoking area. This resident also stated that she was not assessed by nursing for safe smoking.
- An interview with a licensed nurse confirmed that safe smoking assessments are not completed on residents who smoke.

A facility failed to ensure residents were free of accidents during a transfer via a mechanical lift resulting in actual harm to a resident who sustained fractures of the left leg distal tibia and fibula.

- Review of facility policy Safe Resident Handling/Transfer Equipment indicated that patients will be assessed to determine the correct equipment to use, staff will be trained in the use of each type of equipment, and that use of the sit-to-stand lift requires two staff members.
- The resident was cognitively intact and required extensive assistance of two people to transfer. The care plan indicated that the resident was to utilize the sit-to-stand lift for transfers. Review of the Lift Transfer Reposition assessment revealed that the resident was not able to transfer independently or with supervision without using a device and was not able to consistently perform a stand-pivot transfer with limited assist. The assessment indicated that a sit-to-stand lift was required.
- Review of information submitted by the facility to the State agency indicated that a resident was being transferred by a stand-pivot transfer by a nursing staff member, when the resident's foot slipped and the resident was lowered to the floor.
- X-rays revealed a displaced fracture of the leg and the resident was admitted to the hospital.
- An interview with the employee noted that she wanted to use the sit-to-stand lift to transfer the resident from the bed to the wheelchair, but the resident did not want the employee to use the lift. The resident had difficulty on the first attempt but tried to transfer again when the resident's right foot slipped and the resident had to be lowered to the floor.
- The facility failed to ensure that this resident was transferred via a sit and stand lift following the resident's refusal of the sit-to-stand lift. The facility failed to utilize the extensive assistance of two people as indicated in the resident's MDS, which resulted in actual harm to this resident.



The facility failed to implement proper bed positioning procedures to prevent an accident, which resulted in actual harm to the resident who sustained an acute C1 neck fracture, requiring transfer to the hospital for admission and treatment.

- Bed positioning policy indicated that when providing care to a resident in the bed that the resident is rolled towards you.
- The resident care plan indicated the resident required extensive assist of one person for bed mobility.
- A nurse's progress note indicated that while care was being provided, the resident rolled out of the bed onto the floor. The resident's face was red and swollen on the left side. The resident was sent to the hospital for evaluation. The ED report noted the resident sustained an acute cervical fracture.
- A review of the facility investigation indicated that facility staff rolled the resident away from them during care and neglected to follow proper procedure.

The facility failed to implement individually planned and/or effective approaches to prevent a fall for a resident identified at high risk for falls, which resulted in harm to a resident.

- This involved a resident with severe cognitive impairment and total dependence on two persons for transfer assistance and bed mobility. The resident's fall risk assessment identified the resident as being at high risk for falls. The resident's care plan goal was to keep the resident free from falls and injury and a planned intervention was to keep the remote to the resident's recliner on the table, not in the chair.
- A review of a facility incident investigation form indicated that while the resident was in her room, she used the remote control to adjust her recliner chair and elevated it to a standing position. The resident slid out of the chair onto her buttocks and had complaints of pain in her right leg. The resident was sent to the hospital and diagnosed with a fracture.
- The facility's investigation indicated that the remote to the recliner chair was kept in the lower pocket of the chair, clipped to the chair and that the resident does not use the remote. The staff used the chair remote control to transfer the resident out of the chair. According to the DON, an intervention was put in place to have the remote to the recliner out of the resident's reach due to a past history of the resident reaching for the remote. Further review of the facility's investigation revealed no documented evidence of identification of the staff members who had placed the resident in the recliner chair and the location of the remote control at the time the resident was transferred into the chair prior to the fall.
- The DON confirmed that there was no statement from the staff that placed the resident in the chair with evidence of the location of the remote control after staff had transferred the resident into the recliner. The DON also stated that unplugging the chair from the wall outlet would have prevented the resident from using the remote to raise the chair, which had resulted in the fall with serious injury.

The facility failed to ensure that safe techniques were used during mechanical lift transfers, resulting in a fall with an arm and leg injury.

- Manufacturer's directions for use for the Invacare Reliant 450 and Reliant 600 electric portable patient lifts revealed that the definition of a WARNING was a potentially hazardous situation, which if not avoided, could result in death or serious injury.
- The manufacturer's directions, operating information, and sling information all included WARNING NOT intermix slings and lifts of different manufacturers.
- The facility's policy regarding mechanical lift operation indicated to always follow individual manuals for specific lift operation, that all lift slings were to be inspected for normal wear and tear with each use, and that if a lift sling was found to be weak for transfer, it was to be given to the Director of Nursing for inspection purposes. Lifts used in the facility are the Invacare Reliant 450 and Reliant 600.
- The resident required extensive assistance from staff for daily care, including transfers. The resident's care plan indicated the resident was to be transferred using a mechanical lift.



- An incident note revealed that the resident was on the floor after the lift sling broke during a transfer. Two staff members were in the room operating the lift and inspected the sling prior to transfer, and found it was not frayed. The resident was lying on her right side on top of the lift sling. Staff was able to move the resident to remove the mechanical lift from underneath her and while lifting her gently, blood was noted coming from the right forearm. A nurse cut the resident's right sleeve and noted bone sticking out of her skin.
- An emergency department physician's revealed that the resident had a large laceration to the right forearm that was approximately 10 centimeters (cm) and that ten absorbable sutures were placed subcutaneously (beneath the skin) and the wound was closed with 13 sutures.
- A written statement from the nurse aide revealed that she and another nurse aide were getting the resident changed and ready to get her up to her chair. She found a leg lift cover, but she does not like using that type of sling, so she went to the laundry department to get another lift sling. She looked the lift slings over and picked lift sling six, which she felt was a good lift sling. She returned to the resident's room where she and the nurse aide placed the lift sling under the resident and began to lift her. When they started to move the resident away from the bed, the lift sling snapped and the resident dropped to the floor, landing sideways on the legs of the mechanical lift. The second nurse aide witness statement corroborated.
- An incident note form revealed that the resident's family member wanted the nurse to assess the resident's right lower leg. It was noted that the bruise from the resident's previous fall now had a raised fluid-filled blister on it that measured 2.5 x 2.5 cm. A nursing note revealed that while at the hospital for another reason, the resident's right leg was debrided. A nursing note dated revealed that the resident's family member was concerned that there was a pocket of fluid above the wound. The resident's family requested that the resident be seen by a plastic surgeon for wound care. A wound clinic note revealed that the resident was seen for evaluation and management of a hematoma. The note indicated that while the resident was in the hospital for another reason, the hematoma was debrided, leaving an open wound. An assessment revealed a full-thickness ulceration of the right leg measuring 5.0 x 2.5 x 0.5 cm with non-adherent edges, tunneling, and undermining. A plastic surgeon's progress note revealed that the resident had a wound to her right lower leg following a fall from a mechanical lift. The wound measured 5.0 x 3.7 x 0.5 cm with tunneling of 5.0 cm at the 12:00 position and 1.5 cm at the 9:00 position.
- Information submitted by the facility revealed that the mechanical lift in use at the time of this resident incident was an Invacare Reliant 450 model, and that it uses Drive and Invacare brand lift slings. The sling in use during the incident was a Drive brand lift sling and the facility was unable to determine when the lift sling was purchased. All Drive lift slings were removed from service. The information indicated that the Invacare manufacturer recommended using their own Invacare accessories, and all Drive lift slings were removed from use.

Facility failed to assess a resident's ability to safely use a microwave, which resulted in second-degree burns to a resident's thighs thus resulting in harm.

- Review of medical record documentation noted a change in the resident's condition had occurred and documentation indicated that the resident sustained a burn in bilateral inner thighs from dropping her hot soup.
- Facility incident report indicated that the resident was removing her soup from her personal microwave and soup spilled out of the side of the bowl, causing her to drop the bowl on her inner thighs. The areas were assessed as right inner thigh redness of 18 cm x 10 cm.
- The facility had no policy for personal microwave use by residents.

Facility failed to develop and implement fall/injury prevention interventions for residents who were at risk for falls, resulting in a fall with fracture; failed to complete thorough investigations of falls to determine the possible cause(s) and if care-planned interventions were in place; and failed to provide adequate supervision during a mechanical lift transfer.



- The resident was understood, could understand, required extensive assistance from staff for her daily care, mobility and transfers, was not steady and only able to stabilize with staff assistance. The resident's care plan indicated that the resident was at risk for falls related to right-sided weakness and poor safety awareness, and staff were to ensure that she wore appropriate footwear - shoes for transfers, slippers at other times, and a two week trial was to be completed for a sensor pad alarm to the wheelchair and bed, and to check the function of the alarm with each application. Staff was also to respond promptly to the resident's calls. A later revision to the resident's care plan indicated that a wedge cushion was to be placed on the resident's Broda chair and that anti-tippers were added.
- A fall investigation report indicated that the resident was found sitting in her bedroom, near her bed in front of her Broda chair. The resident stated, "I went to get up and slipped and down I went." There was no documented evidence that any changes or new interventions were initiated to prevent further falls and/or injury for this resident.
- A second fall investigation report indicated that an alarm was heard going off and the resident was found about two feet away from her bed. The resident stated, "Sorry, I tripped. I'm fine, help me get up." A revision to the resident's care plan following this fall indicated that the resident was to wear a helmet when out of bed for transfers/ambulation, when cooperative, and that the resident was to have her bed against the wall with a body pillow for positioning and a winged mattress to her bed.
- A third fall investigation report indicated that the resident's alarm was going off and upon arrival in the resident's room, she had walked from her chair near her bed to the bathroom door and was yelling for help. A nurse aide assisted her back to her chair, and a few moments later the resident fell. A nursing note indicated a nurse aide reported that the resident's alarm was going off and when she went into the room, the nurse saw the resident trying to propel herself in her Broda chair. The resident's buttocks slid off her chair and she landed in a seated position on the floor. An assessment revealed that the resident was scooting herself around saying, "Help me." Initially she would not state how she got on the floor, but eventually, the resident stated that she was trying to go to bed. Staff reported that the resident kicked her shoes off and had on socks with no grip. Gripper socks were put on the resident and she was assisted to stand and walk to bed. Staff was instructed that if the resident did not want to wear shoes, they were to ensure that alternate footwear of gripper socks was applied as the resident was at high risk for falls and needed to have some form of non-slip footwear on at all times.
- A fourth fall investigation report indicated that staff heard the resident's alarm sounding and when they reached the resident's room, she was observed sitting on the floor in front of her recliner. The resident stated that she was just trying to get up. There was no documented evidence that any changes or new interventions were initiated to prevent further falls following this incident.
- Interview with the Director of Nursing confirmed that there were no new interventions attempted to prevent further falls and/or injury for this resident and that the investigations of the resident's falls were not thorough because they did not include statements from all staff involved in the resident's care.

Facility failed to provide adequate monitoring and assessment to ensure the safety of a resident with suicide ideation resulting in actual harm of a bone fracture in the neck.

- This involved a resident with a diagnosis of depression and hallucinations. Psychiatric documentation revealed the resident had previously attempted suicide two times. On one occasion the resident overdosed on medication and was found unconscious and on another occasion, the resident had jumped in front of a train. It stated further that the resident was unkempt, thought process was confused, had poor insight, had impaired intellectual functioning, was suspicious, paranoid, mood was worried/anxious.



- A resident plan of care was developed to address the use of medications for anxiety and depression, which included interventions such as administering medications as ordered by physician, monitoring and recording behavior symptoms and verbalized feelings, monitoring and reporting side effects of psychoactive medications, providing emotional support and psychiatric evaluation as needed.
- Nursing progress notes revealed that the resident's spouse had notified the facility that the resident had telephoned the spouse and stated that he was feeling suicidal. Upon assessment the resident stated to the nurse that he was feeling suicidal and wanted to go to the emergency room. The physician was notified, and the resident was transported to the emergency room and was admitted to the hospital. The resident had been seen by psychiatry staff and a geriatric psychiatric inpatient hospitalization had been recommended but the resident's spouse refused. Resident returned to the facility.
- There was no evidence available for review, at the time of the survey, that the resident's plan of care had been revised after he returned with interventions developed to address the resident's suicide ideation. In addition, there was no evidence available to indicate that the resident was being assessed or monitored more closely for self-harming behavior.
- A Late Entry in the medical record noted that following return to the facility, the nurse aide said that she heard three loud thumps, ran in the room to see what had happened and came running out saying the resident was bleeding - there was blood coming from the resident's head. An investigation stated that the resident was found crawling into bed with blood dripping down his forehead from a laceration above his eye and discoloration beside his nose and below his eye. A written statement by the nurse aide revealed that a boom, boom, boom was heard and the staff member ran into the resident's room and found the resident was on the floor with his head bleeding, crying that he threw himself to the floor because he wanted to go to the hospital.
- The resident had a laceration to the forehead, approximately 1/2 inch long that required 4 sutures. A CAT Scan showed he had an avulsion fracture at C3.
- There was no evidence that appropriate interventions to address the resident's suicide ideation had been developed or that the resident's continuing thoughts of suicide or self-harm were being monitored or managed by the staff after the resident returned to the facility.

Facility failed to implement interventions and adequate supervision to prevent accident hazards for one resident which resulted in harm by burns, transfer to a hospital and subsequent transfer to a burn center with admission, resulting from smoking while continuous oxygen was being used by the resident.

- The facility's policy regarding smoking indicated that the facility is a non-smoking facility. Safe smoking will be permitted in an outside designated area for those resident smokers who were admitted prior to the facility being designated as non-smoking. The policy goes on to state that violation of the policy will bring possible discharge from the facility if behaviors present a danger to self or others.
- The facility's Smoking Evaluation completed for the resident states that the resident has been evaluated and IS NOT safe to smoke. The resident is on continuous oxygen. The resident's care plan, revealed that he had chronic respiratory disease, would not smoke unless approved by the facility and an intervention was that resident would be educated on the dangers of using oxygen while smoking. Based on the aforementioned Smoking Evaluation, resident was not approved to smoke.
- A review of nursing progress notes stated staff was made aware that the resident was outside smoking. The resident was re-educated about smoking and how it is harmful to his existing condition and also the dangers of smoking with oxygen. The unit manager was made aware. The respiratory progress note stated the resident was educated on the dangers of smoking while wearing oxygen. A statement written by the Assistant Nursing Home Administrator states that he spoke with the resident about not being allowed to smoke due to the facility's smoking assessment deeming the resident unsafe to smoke. The statement also stated that there are other options available to the resident to help with his nicotine dependence; the resident declined to look into any other option the facility could provide him. There was no documentation in the resident's clinical record regarding this offer of smoking cessation options that could be provided by the facility.



- Interview with Respiratory Therapist (RT) noted she had spoken with the resident numerous times about smoking and he didn't want to quit; that the damage is done. RT also stated that she had spoken with the resident's girlfriend numerous times about his smoking - that resident would sneak off the unit; RT didn't know how many times because the resident would leave with his girlfriend.
- Review of the facility's Elopement Risk Evaluation revealed that this resident was oriented to person and place and was not at risk for elopement, despite the aforementioned sneaking off the unit without signing out.
- A facility report of an incident revealed that the resident left the unit without signing out. He was smoking outside in the courtyard with an oxygen tank on the back of his wheelchair. An Activities Aide found the resident on fire and extinguished the fire with a fire extinguisher. A Licensed Practical Nurse arrived at the scene as the resident was being wheeled in his wheelchair away from the area and brought back to his room to be assessed. The resident was transported to the hospital and subsequently transferred to a burn center where he was admitted with third-degree burns to the left flank, right back and left hand.
- A review of the clinical record post-incident noted the absence of documentation of an assessment by a Registered Nurse while he was still at the facility, prior to his transfer to the hospital.
- The facility educated this resident on the dangers of smoking with oxygen, but offered no other interventions and did not enforce the facility's smoking policy. The facility failed to implement interventions and provide adequate supervision to ensure the resident did not smoke with oxygen to prevent accident hazards for this resident which resulted in harm by burns, transfer to a hospital and subsequent admission to a burn center.

Submitted By:

Candace McMullen, PADONA Executive Director/Board Chair

PADONA's 31st Annual Convention

Wednesday, April 3, 2019 through Friday, April 5, 2019

We changed the schedule for our 2019 convention based on the responses to our recent survey.

[Convention Overview Letter](#)

[Register Prior to January 1, 2019 for a discounted price](#)

Welcome New Members

- Heather Wagner - Quarryville Presbyterian Ret Comm - Area II
 - Najah Sakir-Bass - Immaculate Mary Center - Area III
 - Francis Rubino, PharmD - Friendship Pharmacy, Inc. - Area III
 - Catherine Rodgers - UPMC Sugar Creek Station - Area I
 - Sherry Wildenstein - Spiritrust Lutheran - Area II
 - Jacquelyn Willman - StoneRidge Poplar Run - Area II
 - Tara Pendrak - Cedarbrook Senior Care & Rehab - Area III
-